

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-022955

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **352** Primary Registration District No. _____ Registrar's No. **47**

1. PLACE OF DEATH a. COUNTY Taney		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Taney	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Branson		c. CITY OR TOWN Branson	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home		d. STREET ADDRESS (If outside, give location) Rural	

3. NAME OF DECEASED (Type or print) Grace E. Hillhouse		4. DATE OF DEATH Month May Day 23 Year 1963	
5. SEX Female	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/10/1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN	11. BIRTHPLACE (City and state or country) Branson, Mo.
13a. FATHER'S NAME Martin Jones		14. NAME OF HUSBAND OR WIFE Fredrick Hillhouse	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No		17. INFORMANT Address Ethel Furhop, Branson, Missouri	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY _____ STATE _____
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21. I attended the deceased from 1961 to 5-23-1963 and last saw her alive on 5-23-1963	
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE Charles A. Spears MD	22b. ADDRESS	22c. DATE SIGNED 5-29-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/27/1963	23c. NAME OF CEMETERY OR CREMATORY Ozark Memorial
24. FUNERAL DIRECTOR Walter Cobb	25. DATE RECD. BY LOCAL REG. 6-1-63	26. REGISTRAR'S SIGNATURE Deleu Campbell

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300
Rev. 4/59
1 1060
2 1060
3
4 1
5 1
6
7 0
8 2
9 4201
10
11
12 90-0
13 1-0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4731

P. O. Address Shannon, Va

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.